Treatment Research News

Alcohol, Drugs and Addiction

December 2004 *Newsletter of the Treatment Research Interest Group* **Vol 8 No 3**

EDITORIAL

And another year draws to a close! I'm not sure if it is a factor of age or stress, but time does seem to be passing more and more quickly. Thankfully aside from the occasional thunder storm we have had some spectacular Spring and Summer weather to cushion the blow of another year running out.

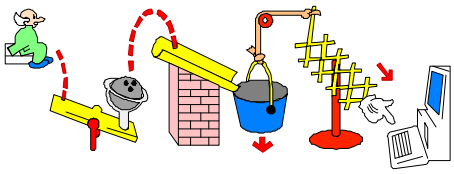
It was fantastic to catch up with the field at this year's Cutting Edge conference (see report this page). There were 350 Alcohol and Drug workers/researchers in Palmerston for the three days of the conference with plenty going on and lots of great information to absorb. As always the opportunity to catch up with like minded people and put faces to names was wonderful. This field is ever expanding – when I joined 5 years ago it didn't take long to learn most of the people around. Nowadays that is quite a task to keep up with.

So welcome to the final issue of the Treatment Research News for 2004. It has been quite a bumper year. More and more research is underway into the treatment of alcohol and drug addiction in New Zealand. The research community is growing slowly, but surely. This issue has some engrossing Summer reading for you. Klare Braye has provided us with an interesting and challenging article on promoting research and strengthening the connection between research and clinical practice. Mary Anne Cooke informs us about screening family members of problem gamblers. Fraser Todd once more provides I've been reading. Tami Gibson and Tracy Haitana report on the Cutting Edge conference. We also have reports from recent conferences attended by Simon Adamson and Murray Hunt. Simon Adamson gives us the NAC report as well as the TRIG Chairperson reports. Last, but not least there are updates on research underway in the Auckland and Wellington Schools of Medicine and Health Sciences.

Now is the time for me to extend a big thank you to those who help to bring the TRN to you three times a year. First of all, thank you to Lisa Andrews who patiently beautifies each issue and Lindsay Stringer who makes sure it is emailed and posted to the Net. Secondly, thank you to Fraser Todd, Simon Adamson and the Abacus Team for their faithfully regular contributions. Lastly, thank you to all the other author who have put up with my consistent reminding and produced such good reading for us this year.

So from the TRN team relax, enjoy the summer sun and have a very Merry Christmas and wonderfully happy New Year. We will see you again in April 2005. And of course - happy reading.

Meg Harvey, Editor, 10 December 2004



CUTTING EDGE CONFERENCE REPORT

The city of Palmerston North played host to the 9th Cutting Edge conference for alcohol and Other Drug treatment and research workers, held earlier this year from the 2nd to 4th September. The event attracted well over 300 delegates - the largest number of attendees to date - attesting to the value and high regard in which this conference is held.

This year the overarching theme of the conference was 'Integration', with many of the presentations exploring the challenges of an integrated approach to addiction, including its incorporation within the broader area of mental health. Presentations and workshops were both stimulating and informative, with a wide array of treatment and research topics being covered. Gambling featured prominently this year, as well as other relevant national issues and topics. These included presentations and posters on methamphetamines, methadone maintenance and issues for Māori and Pacific Peoples in the Alcohol and Drug field.

This year the John Dobson Memorial prize for the best presentation on an opioid topic was awarded to Tracey Fearn for her paper on "GP Authorisation: Creative Thinking to Encourage GP Participation in Methadone Treatment Programme". Ata Samu was the recipient of the John O'Hagan prize for the best presentation by someone under the age of 35-years for her paper "Treatment Delivery the Pacific Way - An Exploration into Delivery of Alcohol and Drug Services for Pacific Peoples in New Zealand". This year saw the introduction of the DAPAANZ prize for a practitioner who presented/reviewed their work. The prize was awarded to two outstanding presenters, namely: Dick Johnstone for "Me Whakahaere Katoa, Kaua e Whakarerea: Include Everything, Don't Leave Anything Out" and Ken Branch for his presentation on "A Programme for People with Co-existing Traumatic Brain Injury and Substance Abuse".

The NAC have produced Cutting Edge Proceedings from the conference (available on their website – www.addiction.org.nz) and TRIG has once again been charged with the task of compiling a Monograph from the research stream (with Simon Adamson as editor).

Tami Gibson & Tracy Haitana
Māori Indigenous Health Institute

THE FORGOTTEN FAMILY

Addiction services have historically focussed upon providing help for those exhibiting problem gambling behaviour. However, often overlooked is that their family/whanau experience as much or more financial hardship, as the person who has the gambling problem. For many families, the continual stress of living with emotional and financial uncertainty results in poor mental health, with conditions such as major depression, anxiety disorders and suicidal ideation being almost as commonplace as for those who have the gambling problem. The Australian Productivity Commission identified in 1999 that each problem gambler adversely affected at least seven others. Nevertheless, family/whanau of problem gamblers comprise only a fraction of the numbers in the problem gambling area who seek help. In 2003, barely 30% of first time calls to the national helpline came from significant others while face-to-face counselling statistics revealed that only 20% of clients were family members confirming that, as with other countries, help-seeking by family members in New Zealand is proportionately well below the expected needs.

Identifying and minimising the harm caused by gambling to family/whanau is recognised in the new Gambling Act. However, for possibly a range of reasons, help-seeking for these people remains low. This suggests that to minimise harm for this significantly larger group than problem gamblers, a proactive approach is warranted. Recent screening projects of at-risk groups within New Zealand have identified substantial numbers of family members adversely affected by another's gambling.

How does problem gambling affect the family/whanau?

Problem gambling can consume vast amounts of money over a very brief period. Even a five-cent gambling machine can consume hundreds of dollars in an hour. As larger bets and/or longer gambling sessions develop, demonstrating a form of 'tolerance', the person gambling needs to access money from new and sometimes unauthorised sources. Multiple credit cards, bounced cheques, personal loans, mortgages and 'borrowings' from work money can very quickly exceed the ability to repay. The fear of criticism, disclosure, family arguments compounded with shame, guilt and past lies, often means that the family does not become aware of the level of debt until late stage problem gambling.

This can, for the family/whanau, result in:

- Shock and anxiety for the family's immediate and future financial security, and change in status
- Shame around the public perception of the family and their predicament
- Depression around ability to solve apparent unsolvable problems and loss of motivation
- Loss of trust caused by the deceit
- The ending of relationships and stresses associated with this
- May result in violence between the gambler and partner/spouse
- Loss of guidance and focus on children of the family as the partner becomes overly focused on trying to control the gambler's behaviour
- Loss of employment for the gambler and income for the family
- Health problems resulting from unrelenting stress on the family
- Control issues by the gambler over the partner/spouse that isolates the family from help
- Suicidal ideation/attempt by the partner/spouse or guilt as a result of the gambler's suicidal ideation/attempt
- Uncertainty as to where to seek help due to a complex mix of effects, with focus upon finances and disconnection from or devaluing their own health needs

A screen developed to identify those affected by another's gambling

As has been described, concerned others may be affected by problem gambling in a range of ways, including their personal health, their relationships with others, intergenerational consequences and consequences for society as a whole. Families suffer financial, physical and emotional problems; spouses suffer a range of health problems including chronic/severe headaches, stomach disorders, breathing difficulties and light-headedness, depression, feelings of anger and isolation (NRC, 1999) or may be physically abused (Lorenz et al 1993; Bland et al 1993). Children of problem gamblers were more likely to smoke, drink alcohol and misuse drugs, and describe their childhood as unhappy (Jacobs et al 1989) while frequently reporting anger, sadness and depression (Lesieur et al 1989) or physical abuse (Bland et al 1993). A study of NZ General Practitioner patients (n=752) found that 40% of patients who were not problem gamblers themselves, knew of problem gamblers who were friends or family members (Sullivan 1999).

There is often shame and guilt experienced by the concerned other as a result of either harbouring a belief that they are contributing to the gambler's behaviour, having 'family secrets' around the gambling through borrowing from relatives or friends for 'other' reasons, or around protecting the gambler/family from creditors or criticism.

How can the concerned others screen assist?

Screens can elicit a true response if provided in a safe and appropriate environment. This screen is described as a health survey for the concerned other; the health perspective can help in avoiding the focus on behaviour that the person may be either ashamed or protective about. The responses to choose from are broad, and even if the person chooses incorrectly to not disclose, it may 'sow a seed' around the effects on themselves of the gambler's behaviour, instead of the focus (often) on the gambler. Also, if offered in a health environment there will be an expectation that such questions around health will be asked. Other suitable environments may be budgeting, refuges, employee assistance programmes, family counselling, and many others.

The screen questions

The screen comprises just three questions in order to encourage participation and utilisation. The first question is a cut-out question which enables those not affected to discontinue with the screen. Those uncertain, affected in the past or currently, continue to the second question.

The second question encourages thought around the effects of another's gambling <u>on themselves</u> and enables a range of responses including 'uncertain' that may foster further thought. A multiple response is also available.

The third question allows the person to indicate the assistance they would like. It is client centred and includes the ability to decline assistance. Hopefully this freedom to choose not to seek help will allow the perception that a truthful answer is available without the expectation of pressure to address the response there and then.

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Data collection is now coming to an end for the 2004 National Telephone Survey of the AOD workforce. The project has repeated, with a few additions, the methodology of the 1998 National Telephone Survey of the dedicated AOD workforce. A "dedicated AOD worker" was defined as paid workers, 70% or more of whose client contact is with AOD clients. The timing of the 2004 survey was prompted by the establishment of the National Addiction Treatment Workforce Development Programme.

In total between 280 and 290 randomly selected alcohol and drug treatment workers (ADTWs) will be interviewed. Findings from the first 150 interviews were presented at Cutting Edge 2004.

Three significant changes between 1998 and 2004 in demographic profile were revealed. The mean age of the field increased from 42 years in 1998 to 47 years in 2004, with a halving of the proportion aged under 35 years. There is a significant reduction in the proportion of the field identifying their current drinking status as "ex-drinker", from 36% in 1998 to 26% in 2004. Number of years working in the AOD field increased significantly, from a mean of 5.7 to 7.9 years.

The aging of the workforce has significant implications for longer-term retention and the ability to adequately cater to younger-aged clients. The increase in average age can be partly attributed to increased staff retention, but is clearly the result of other forces also.

One of the most positive findings was a highly significant increase in level of highest academic qualification, with the proportion of the field with postgraduate qualifications (39%) more than doubling since 1998 (17%), while the proportion of those with secondary only or no formal qualification has reduced from one in four (26%) to one in seventeen (6%). In total 57% of respondents had completed an AOD-specific tertiary qualification, with 13% having completed postgraduate AOD-specific qualifications. In 1998 these figures were 47% and 3% respectively. The increase in postgraduate qualifications should be particularly encouraging for members of TRIG and other readers of the TRN, as it suggests that the capacity of services to engage in clinical research is likely to have increased.

The increasing qualification level of the AOD workforce is likely to continue to increase, with 41% of respondents reporting that they were currently enrolled in tertiary education, 19% in AOD-specific courses and 26% in other courses (with some overlap).

ADTWs were asked "How supported are you by the manager of your service to improve your treatment knowledge and skills?", with the response options of: very (54%), a lot (12%), moderately (19%), a little (8%), and not at all (7%). They were then asked "Can you undertake as much training as you need to do your job well?", with 66% responding Yes. Those responding No gave the primary reasons for being unable to undertake training as funding, time or availability of leave, and high workload. To a lesser extent unsupportive management was mentioned by some. This high level of support for ongoing training identified by respondents was gratifying, and helps explain the high proportion of the workforce currently enrolled in formal training.

In addition to the information described above, clinicians were asked questions relating to knowledge, attitudes, current practice, and optimal practice. We will be taking a closer look at these questions once the full data from this survey have been collected and entered. These findings will be presented in a range of venues, including TRN. It is also our intention to again repeat this survey in the future, and we would expect a shorter time lag than the six years between the first and second surveys.

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Treatment Research News is the official newsletter of the **Treatment Research Interest Group (TRIG).**

TRIG was established in 1997 to promote research in the alcohol and other drugs field in New Zealand.

The **executive committee** are: Simon Adamson (Chairperson), David Benton, Raine Berry, Alistair Dunn, Meg Harvey (Editor), Janie Sheridan, Lindsay Stringer (Secretary)

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APSAD Conference 2004

The 2004 APSAD conference took place in Fremantle, Western Australia in mid-November. The conference theme of "Beyond the Drug" allowed for a rich diversity of content; papers covered a spectrum from effective prevention through to treatment, and from individualised interventions through to global approaches to policy. Organisation of the conference was first class; food and venue was great, and the trade displays offered a wealth of resource material (my bags weighed some 15 kg heavier upon return to New Zealand!).

APSAD conferences provide one real challenge; so much content means that up to 6 sessions (break out-groups) run concurrently. Choosing your stream is difficult, invariably you want to be in 2 or 3 places at once.

The APSAD conference ran for 3 days, and was preceded by a ½ day workshop around buprenorphine. Dr Leslie Amass presented US experience on suboxone (suboxone is the trade name for buprenorphine/naloxone combination). A key message in this talk was that for all essential purposes subutex and suboxone could be seen as the same medication. The one advantage of suboxone is that the presence of naloxone in the sublingual preparation is a deterrent for intravenous injection. A standard dose tablet contains 8 mg buprenorphine and 2 mg of naloxone, this being 5 times the dose of naloxone needed to reverse a heroin overdose.

Professor Walter Ling addressed the buprenorphine symposium around the increased use of opioid medication for chronic pain states. As opioid prescriptions increase, so does opioid abuse. In 2002, it is estimated that some 30 million people world-wide used prescription opioids in a non-medical sense. With respect to buprenorphine, Professor Ling suggested that this medication has no ceiling effect as an analgesic. This is in marked contrast to the way in which we would view buprenorphine in the management of opioid dependence. I would have liked to have seen this point further developed and supported with more scientific evidence.

Dr Tracey Westerman provided the opening plenary for the APSAD conference. She spoke around psychological interventions for indigenous people. She talked of the three big dilemmas: misdiagnosis, over diagnosis and under diagnosis. Dr Westerman highlighted the disadvantage that the Aboriginal people face, especially with respect to mental health and substance related issues. She notes that the Aboriginal people themselves will identify cultural triggers to these problems and cultural solutions earlier than external providers. With respect to level of engagement at mainstream services, Aboriginal people attend an average of one session in contrast to 6 sessions being an average level of engagement for non-indigenous people. Dr Westerman went on to talk about a cultural competence continuum as part of workforce development.

Dr Mike Farrell, National Addiction Centre, London, highlighted the impacts of comorbidity on a substance using population. He spoke of addiction services within the UK being operated within the mental health umbrella, but he suggested that large interface problems still occur. He saw a challenge for the future as providing more user friendly, more accessible services to clients. Dr Farrell spoke of the singular lack of tackling tobacco use in mental health services and he anticipated that this would change significantly over the next decade.

Data from an Australian first episode psychosis outcome study was presented. This was a big study; it involved 786 subjects in the age range 15-29 years. Sixty-one percent of the subjects had a current substance use disorder at time of presentation with psychosis. Cannabis was by far the most common substance implicated. No subjects with a substance-use diagnosis were found to have a lower level of pre-morbid functioning. Persistent substance use was associated with worse outcomes across several domains.

In an opioid symposium, Dr Mitchell told us about the risks associated with the misuse and diversion of methadone. In the UK, there are some 3,000 drug deaths each year and about a third of these involve heroin or methadone. In fact, methadone features in 50 percent of fatal opioid overdoses in the United Kingdom.

Dr Mitchell went on to describe an advanced methadone dispensing system. This is a titanium canister, about the size of a thermos flask. The canister can be accessed by a pharmacist and will hold a 500 ml bottle of methadone. It is tamper resistant, bullet resistant and so forth. The device contains advanced electronics, which allows it to be programmed to allow fixed access to a daily dose of methadone following finger print identification of the intended recipient. The methadone is dispensed through a spout in the canister. Of course there is nothing to stop the intended recipient than passing the methadone on to a third party. The canisters are about to go into commercial production and it was suggested that they could be a cost-effective delivery system (there is potential to save multiple pharmacy dispensing fees). Certainly, this was a novel device with tonnes of potential for additional information (e.g., it can tell us precisely when a patient accesses their dose), but will we ever see it in New Zealand?

I attended two symposiums which focussed on methamphetamine. A number of Australian research groups have randomised controlled trials underway; an acute care trial is comparing benzodiazepine alone with benzodiazepine with a typical antipsychotic for the treatment of methamphetamine induced psychosis. Another randomised-controlled trial is further investigating the role of dexamphetamine as a short-term substitute, coupled with psychotherapy. A controlled group will be on placebo medication, again with psychotherapy.

Dr Amanda Baker reported on a completed study that further explored the role of psychotherapy in methamphetamine users. A control group was offered assessment and a self-help book, whereas the active intervention consisted of either 2 sessions or 4 sessions of psychotherapy (motivational interviewing with additional behavioural therapy). Nintey-one percent of the sample were injecting drug users and half of them were using amphetamines on a daily basis. Twenty-five percent of the subjects were enrolled in a methadone maintenance programme. They scored highly on SDS scales for amphetamine dependence. There was also high mental health comorbidity with two thirds of the sample assessed as moderate to severe on the Beck Depression Inventory. There were no significant differences in mean amphetamine use when the active interventions were compared with control.

At 6 months follow-up, more than half of the sample were still using amphetamines at least once per week, this being the initial threshold for study entry. Subjects randomised to the 4-session intervention, showed greater improvement in depression scores. It would seem that we still need more effective interventions for problematic amphetamine use; Dr Baker's study showed that psychosocial interventions hold potential to attract and retain clients in treatment, but the intervention still doesn't have enough impact on the subjects amphetamine use.

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Developing a Culture of Research to Support Clinical Practice

There are some distinct challenges to conducting research. Not least is the time and resources required to actually do it. However, to develop a 'culture of research' within our service was a notion presented at the Central Regional Mental Health and Addiction Network Speakers Day in Palmerston North last month. It was a paper that looked at what the role of research within a Mental Health/Alcohol and Drug Service would encompass, what the spin offs were for the team and how we could work to develop an organisational and national culture of research that supported clinical practice.

Slotted in amongst all the amazing work that services are doing to engage and support tangata whaiora/clients and the consumer involvement collaborations, this paper was somewhat more academic! Its point of commonality though, was that every paper presented that day talked on some level about research: be it statistics of clients accessing services, comparisons of year-to-year data, anecdotal outcomes figures from overseas, ideas and concepts developed from previous initiatives, or just an acknowledgement that there was no time or resources to review outcomes of the work being done.

So when we talk about research, it is important to note that the concept is larger than academia and clinical trials. It is wide and diverse, including things such as: audits, quality, enquiry, evidence-based practice, statistics, verification, knowledge, trials, studies, exploration, anecdotes, comparisons, literature, reviews, outcomes etc. My proposition, to clinicians, team leaders, management and the funders, is that a culture of research needs to be developed within our services. This is not to sit aside and separate in a little office, developing forms and crunching numbers, but within and alongside, supporting as well as being guided by the clinical team.

Much of our AOD research, as in any field, comes from overseas, particularly Australia, Britain and America. To some extent, that may be acceptable. They have the funding opportunities and the dedicated researchers and we can glean information from their monies and efforts. However, they also have different polices, drugs, cultures, populations, policing, trafficking, service delivery and funding. We are a small island surrounded by sharks and border patrols; we have a good growing climate, green fingers, an interest in organics and hydroponics, hills to hide in and room to grow; we have organised institutions to manufacture and supply; we have cultural and population differences; our policies are based on guidelines around 'harm minimisation' rather than a 'war on drugs' and we have 'kiwi ingenuity' and the ability to adapt. A point to highlight this is the use of opiates. Many developed countries are dealing with the management of heroin use. We, however, tend to buy our 'pharmaceuticals' with packaging and labelling. Consequently users regularly know what they are getting, there is reduced risk of overdose, use is often at home resulting in less needle use in public places, and ingenuity around poppy seed tea provides a self-controlled alternative for treatment and management. Consequently we have quite unique differences in terms of our service provision, police policies, treatment options, funding etc. New Zealand is unique and we must put research into that context.

We have a number of research assets and they must be credited for their work. Namely, the endeavours of the NAC, APHRU and police research initiatives; publications of TRN, NZDF, ADA and journals such as NZMJ, DAReview, ANZJP (although they are either medical or joint with Australia); support through NZDF and ALAC; access to scholarships, grants and HRC funding and organisation of conference, in particular Cutting Edge, but also Australian joint ventures and Speakers Days.

I am not proposing that each clinical team has a research team attached or focused on writing for publication. I am suggesting more that research becomes a part of the service structure, that it is supported in the team in order to support clinicians and that it is recognised as being of value to service provision by management and the funders.

There are problems with this idea of course, including the fact that some people are just not interested. There are also the cries of: there is no time; what about the waitlist; we need more clinical staff, not pen pushers; we're not supported to do research; I don't have time to read TRN, (I don't even know what TRN is!); someone might want to assess my work; it interrupts the therapeutic process; not more forms!!!. They may be very valid arguments, but in the true therapeutic process, we also need to review the benefits and see that they clearly outweigh the 'not so good'.

There are benefits to the team and service delivery. If we are able to integrate research to support clinical practice we can, for example, support and provide input in to MDTs and case reviews; identify relevant and interesting research items; comment on/support/lobby on Government policies and funding; improve staff retention, satisfaction and continuity; encourage service development and assessment through auditing; carry out service evaluations, (new vs. old service initiatives); facilitate interfacing with other services; respond to ever changing patterns of use; use appropriate or new treatment approaches; and benefit from supervision, training, and treatment provision through outcomes trials. This has a roll-on effect to our tangata whaiora/clients as well as the additional obvious benefits of having a team providing evidence based/informative clinical practice and the development of appropriate resources to better support clients and support persons.

Furthermore, in terms of public health and the wider population, research can help to raise the profile of our work, reducing stigma and offering better integration. We can better inform policies and decision making, such as the suitability and supports required for prescribing of naltrexone. On a more personal/professional development level (which is so important and topical at present with DAPAANZ registration and the NATWDP initiatives) a culture of research can develop and encourage critical/ethical thinking and skills, support individual interests and/or further study and work towards workforce development and capacity building.

Then there are the benefits to management, of which everything listed above must have value, but also the benefits of staff retention and satisfaction, the fact that discussions and presentations lead to more discussion and presentation which leads to more interest and staffing (e.g., knowledgeable GPs and interested Psychiatric registrars), that there could be better utilisation of services, that clinicians would have the skills, time and interest in carrying out audits required for accreditation, certification and quality co-ordination, that specific outcome audits can be utilised for service development and business planning, and that ultimately we can build on strengths and be attentive to the shortfalls.

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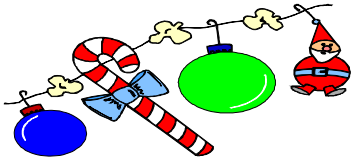

Message from the Chairperson

The 2004 AGM for TRIG was held in September at the Cutting Edge conference, hosted this year in Palmerston North, and was attended by a small, but enthusiastic group. The new executive voted for at this meeting are:

- Simon Adamson (Christchurch, Chairperson)
- David Benton (Tauranga)
- Klare Braye (Wellington)
- Alistair Dunn (Whangarei)
- Meg Harvey (Christchurch – Editor, TRN)
- Janie Sheridan (Auckland)
- Lindsay Stringer (Christchurch – Secretary/Treasurer)

An especially warm welcome is extended to Klare Braye who is newly elected to the executive.

One issue raised at this meeting was the suggestion, by Associate Professor Doug Sellman, that TRIG consider changing its name to the Addiction Treatment Research Interest Group (ATRIG), as a more specific descriptor of the focus of the group, and as an explicit means of including non-substance based addictions such as gambling. Time did not allow for full discussion of this at the AGM. I would welcome any comment on this suggestion from the membership.

Acknowledgement of the importance of gambling would certainly be timely, given the process currently underway within the Ministry of Health to align funding and provision of pathological gambling treatment more with the alcohol and drug treatment community. TRIG is very well placed to accommodate this transition given past inclusion of gambling issues in the TRN and current membership, which includes a number of people with specific interests in this area.

Cutting Edge was a great success with the largest attendance record to date (339), and some excellent research presentations. The 2004 Treatment Research Monograph is currently in preparation and should be distributed in February 2005.

This will be the fourth Treatment Research Monograph. As an annual record of research presented at Cutting Edge the Monograph serves a vital function as a permanent record of research, which in many cases will otherwise have not been published. Given the developmental stage of the addiction research community within New Zealand, this represents a significant mechanism for fostering greater engagement in treatment research and ensuring dissemination of research findings.

I'd like to extend my best wishes to our members and readers for a relaxing and enjoyable Christmas and New Year.

Dr Simon Adamson
TRIG Chairperson

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The Forgotten Family - Continued from Page 2

Intervention responses to the screen

The appropriate interventions to the screen responses are best initially determined in reverse order, namely from the responses to question three.

Mary Anne Cooke
Abacus Counselling and Training Services Ltd

Copies of the Three Screening Questions (and the algorithm) are available from the editor, as well as copies of Sean Sullivan's Concerned Others Gambling Screen (COGS). Email Meg Harvey at meg.harvey@chmeds.ac.nz

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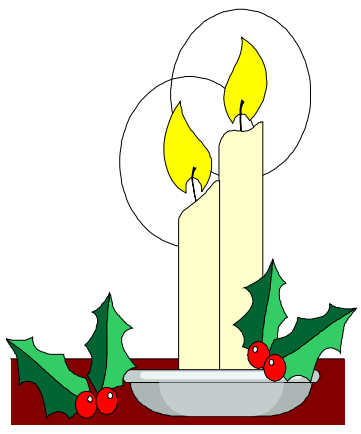
Developing a Culture of Research to Support Clinical Practice - Continued from Page 5

With all these 'good things' that can arise how do we go about doing it? We have had a research role at the Wellington Alcohol and Drug Service, CCDHB for several years, very part time (0.2FTE) often reprioritised (down to nothing), and not always formally recognised. However, the team has plugged away at it and it is getting stronger. There are a number of initiatives that we have identified that can encourage the concept. These include setting up a Journal Club, making someone responsible for printing out and circulating TRN or requesting journal contents pages, circulating relevant articles to the team or individuals, and by establishing a notice board dedicated to abstracts and articles of interest. You can incorporate research into the Clinical or Business Meeting – making it an agenda item, identify areas of service shortfall, frustrations or new initiatives, audit them, before and after implementing changes, and gain consumer input. You can talk to other services about what they are doing, so you are not reinventing the wheel or get placements involved, doing the hard yacka of setting up initiatives and then run with them. Much of this involves getting management and the funders on side as it is about resourcing and support, but this lobbying can be done through business plans, service development and quality initiatives. They can then support us by writing research time in to IECs and CCs, (as is done with the medical profession where 30% of time is specified as appropriate to spend on 'non clinical work'). They could even support a dedicated research role and job description whose position it is to facilitate the team's clinical practice.

This is not about turning clinicians in to researchers, but about turning research to support clinicians.

Klare Braye
CADS Wellington
CCDHB



Auckland School of Medicine

Currently, research is being undertaken by the members of the Alcohol and other Drug Research Collaboration (ADRC), Faculty of Medical and Health Sciences, the University of Auckland.

ADRC members are involved in a number of research projects, and the following is a brief summary of some of these. A number of our recent studies have mainly focussed around methamphetamine use. The first involves in-depth interviews with a treatment sample of methamphetamine users, exploring the ways in which they used the drug, any harms associated with use, access to treatment and access to information about the drug. Users have been accessed through the CADS units and snowballing. The preliminary findings were recently presented at APSAD, and focussed on some of the health issues raised in the interviews and potential for future interventions. A second study is exploring issues around methamphetamine and injury, for example drug-driving injuries, violence, and injuries related to manufacture. The study is taking a multi-method approach and the primary objective is to explore the usefulness of these methods in collecting data on methamphetamine-related injuries. There are three main parts to the research – in-depth interviews with users, self completion questionnaires with attendees at a large one-day music festival, and key informant interviews with groups including police, paramedics, security staff at hospitals and clubs amongst others. A third study, is exploring the impact of maternal methamphetamine use during pregnancy on child development, and is being conducted in collaboration with a multi-site US study.

Other research is exploring barriers and incentives with regard to transferring opiate dependent people from clinic to GP care, through the use of self-completion questionnaire with clients. In another study, the general health of drug users is being explored, to ascertain participants' need for, and use of, primary healthcare practitioners to manage health issues, which are commonly associated with drug use, such as constipation, dental problems and insomnia. This follows on from a study that explored the potential for community pharmacists to take on a more proactive role in this area.

A collaboration between Waitemata DHB and the University of Auckland, funded by ALAC, is undertaking the development of a screening and outcomes tool for youth substance use, and preliminary testing is currently underway with Māori, Pacific and mainstream services, as well as in the school population. It is being designed to work in conjunction with the Strengths and Difficulties Questionnaire (SDQ).

A follow-up national survey of methadone prescribing in New Zealand has recently been completed, and data are being processed and compared with data collected in 2003. Finally, international collaborations are underway to develop research around the role of community pharmacists with regard to problematic alcohol consumption.

Janie Sheridan

Wellington School of Medicine and Health Sciences

An interesting educational research project has just been completed at Wellington School of Medicine and Health Sciences. This looked at the transformative nature of the learning when medical students are exposed to AOD clients very early in their training. A multidisciplinary team of: conversation analyst, educationalist, social scientist, nurse and Addiction doctor analysed the data. The results show a dramatic learning transformation in medical students after an early AOD experience bringing about both a change in meaning scheme (or "attitude") on AOD issues, and a change in perspective (a "paradigm shift") about addiction. This research was presented at the Tertiary Education conference in Wellington in late November.

Senior medical students have just completed their final formal examinations in Christchurch, Wellington and Dunedin. From the examiner point of view it was most interesting to observe how many of these future doctors did not think about alcohol when they were asked to give lifestyle advice to a (hypothetical) overweight patient with high blood pressure. This observation could indicate a need for better integration of alcohol and drugs topics into all the other health topics that are taught during medical education. There is surely a fascinating research project here for someone with an interest?!

Summer research students have descended upon Wellington School of Medicine and Health Sciences to start their projects. This year, for the first time for many years, there are no student projects specifically on AOD issues. The AOD research field really needs to be up there every year with topics for student summer projects. Student summer research maintains the visibility of our discipline for these health professionals of tomorrow, and it highlights the AOD potential as a future career choice. Colleagues in the field are urged to keep their eyes and ears open during the coming year for small "doable" research projects to employ a medical student for the next summer vacation. Our workforce could reap the benefits from nurturing enquiring minds.

Helen Moriarty

Continued from Page 4

Professor Jason White presented the James Rankin oration, which was entitled "Neuroscience to Treatment: What does the future hold?". As we further understand the biological basis of dependence on substances, Professor White suggested that new pharmacological agents will emerge by design. He postulated that some of these may be quite different from our current narrow range of pharmacotherapies and that new medications may shape the way that our drug and alcohol services develop in the future. Professor White highlighted that possible interventions included preventing a substance reaching its site of action (antagonist medications or vaccines), further development of substitute medications, and new initiatives to reduce the responsiveness of the reward system. He suggested that if new knowledge allowed one to prevent the adaptations that led to tolerance and dependence, we would be several steps closer to a cure for addictions. He used minimal studies to illustrate these concepts. Professor White emphasised that prevention will ultimately be easier than reversal. I found this a fascinating oration indeed, especially when I had recently heard Associate Professor Doug Sellman, raise a hypothetical question in a similar light (One day will a pill be the sole intervention for alcohol dependence?).

There were some well-presented and highly informed poster presentations. Again, these covered diverse subjects including "Who stays, Who goes?", with respect to residential drug and alcohol treatment for young people. Another series of posters looked at screening and brief interventions for drug and alcohol use in teaching hospitals. This area remains poorly attended, although providing personalised communication to resident medical staff around their use of screening tools and such like seems advantageous. One poster that particularly caught my eye related to the use of acamprosate and naltrexone amongst an alcohol dependent population. Prescription data was accessed for the 2001, 2002 year. It was estimated that only 3 percent of the Australian population dependent on alcohol take up prescriptions of either acamprosate or naltrexone per year. The repeat prescription rate was low, indicating that treatment regimes are often not completed. Older persons receive prescriptions at a much greater rate than younger people, despite the fact that the prevalence of alcohol dependence is higher in a younger population.

APSAD 2004 was a great conference. Next year the conference will be in Melbourne and, here's hoping, the 2006 APSAD conference may be in Auckland.

Dr Murray Hunt
Clinical Director, CADS Hamilton

Health Outcomes 2004: Perspectives on Population Health, Canberra

This was the 10th annual Health Outcomes Conference. It has no major sponsors, and was described at the opening as bottom up, practitioner-driven. There seemed to be quite a sense of satisfaction with having battled against the odds and the idea that the whole thing might be just a fad. I expected Gloria Gaynor to burst out from the speakers at any moment.

I was impressed that the conference seemed to be the focal point of quite a positive movement – a group of people with a sustained interest in outcome measurement and a belief that it was an important tool to improve practice. There was a nice combination of science and application. Very little in the way of policy-oriented presentations. People mostly talked about what they were actually doing.

I presented data from an AOD service survey as part of the Alcohol and Drug Outcome Project (ADOPT) and implications of the findings for the final recommendations. This was part of the New Zealand Mental Health Research and Development Strategy (MHRDS) sponsored session. There were also presentations from Jim Burdett (importance of consumer participation in the development of outcome-focussed service culture) and Assoc Prof Fred Seymour (NZ Child & youth outcomes measures – a project undertaken with the Werry Centre).

I got a general impression from the conference that mental health is a lot more advanced in its routine measurement of outcome than AOD – with greater consistency of service delivery and better funding (partly due to larger size perhaps) to have dedicated research/computer/data staff.

Two presentation highlights were:

Prof Robert Cummins talked about the concept of "Health-related quality of life". Given the rather disappointing difficulty in finding changes in quality of life measures with health interventions an attempt has been made to focus on health-related QoL. Prof Cummins argued that this was fundamentally flawed as QoL is actually fairly stable, based in part on underlying personality. QoL, or "wellbeing" was described as a homeostatic process, so that the impact of stress on wellbeing was non-linear – i.e., stressors have less of an effect on wellbeing than might be supposed. Furthermore health status was only one of seven domains (including self-esteem, safety, relationship satisfaction, financial security etc) and is actually one of the lessor contributors to QoL. What all this meant to me was that it is perilous to measure QoL as a marker of treatment outcome as it over-estimates the potential impact of health interventions. As an aside, it was also pointed out in a different session that although the SF36 is often described as a measure of health-related QoL it really is more of a measure of symptoms.

Associate Professor Kathleen Wyrwich discussed different ways of determining what constitutes significant clinical improvement as opposed to statistical significance. She talked about methods of surveying service users and clinicians and also suggested using "distribution based" methods – i.e., effect size or standard error of measurement (SEM). There seemed to be some convergence between these different methods so that an effect size of 0.5 seemed to be a good cut-off to use. This ties in with Cohen's interpretation of ES 0.5 – 0.8 as medium and 0.8+ as large – although it was pointed out that this really applies to changes for a group. When looking at change for an individual using an ES (based on appropriate normative data) of 0.6 – 1.0 and 1.0+ respectively was recommended.

The conference and a visit to the federal parliament got me thinking about the contrast between Australia and New Zealand and the significance of the contribution we can make to clinical and policy innovation despite our small size. In specific areas, like development of policy and practice in areas like health, education, and justice, almost nothing happens "in Australia". It all happens at a state level, although anything requiring legislation has to get through both the lower and upper houses at state level, and may be subject to intervention by the federal government, again requiring upper and lower house approval. On this basis NZ is a dramatically simpler place to get things done and would actually equate to one of their larger states on a population basis (not that we'd ever want to actually become one!). So, New Zealand's historic reputation as the worlds "social laboratory" might still have legs. It's also worth mentioning that there was a genuinely warm welcome extended to New Zealand delegates at the conference, with real interest shown in what we were doing.

Dr Simon Adamson
National Addiction Centre

I've Been Reading ...

Treatment for adolescent mental health problems is generally poorly supported by a sound research base, and most interventions are those used in adults with a few minor adjustments, based on the assumption of what works for adults should work for adolescents. Given the lack of a sound current research base, this approach is probably as good as any. However, research is emerging that is specific to adolescent substance use problems.

In this installment of "I've been reading" I have decided to limit myself to a single journal. The November 2004 Supplement of the journal Addiction is dedicated to adolescent alcohol and drug issues and presents several original research papers and review articles. While the approach is typically American, there is a considerable amount of valuable material worth looking at.

Clark reviews "The natural history of adolescent alcohol use disorders" (**Addiction 2004;99(Suppl, 2) :5-22**). Firstly, it appears that few adolescents manage to sustain abstinence from alcohol following treatment for alcohol use disorders, but many reduce consumption to non-problematic levels and manage to sustain this over the longer term. Thus abstinence appears to be no more appropriate an outcome goal than controlled non-problematic use, and far less achievable. Secondly, adolescent-onset substance use disorders appear associated with higher levels of childhood psychopathology and a more rapid transition from first use to dependence than early adult-onset substance use problems. This highlights what appear to be key predictors of adolescent substance use disorders - childhood mental health disorders especially conduct disorder, ADHD, major depression and anxiety disorders. These disorders do not appear to be independent of each other phenomenologically or aetiologically, and the concept of psychological dysregulation has been proposed as a common organizing concept that underlies substance use problems, psychopathology and risk taking behaviours in adolescence. It appears highly heritable, but at the same time is influenced by environmental experiences such as low levels of parental monitoring, inconsistent disciplinary practices and maltreatment. It has also been correlated with frontal lobe abnormalities. Third, the concept of dependence may not fit the nature of problematic adolescent substance use. Adolescents may meet DSM-IV diagnostic criteria for one or two dependence symptoms, but not for a diagnosis of abuse or dependence, and yet still have outcomes similar to those with abuse warranting diagnostic consideration. Furthermore, the diagnostic criteria around key early symptoms of dyscontrol appear to have limited validity in adolescents. The article continues to discuss various aspects of the course of adolescent alcohol use problems, especially the high rates of natural remission over time, but as is often the case in the American literature fails to distinguish adequately between levels of severity whilst doing so.

The research base for various interventions in adolescents are discussed in subsequent papers. "Motivational enhancement and other brief interventions for adolescent substance abuse: foundations, applications and evaluations" (Tevyaw and Monti, **Addiction 2004;99(Suppl, 2) :63-75**) indicates that there is emerging evidence for motivational approaches in younger people both as a stand alone treatment and as a front-end, much as it might be used in adults.

The evidence for cognitive-behavioural treatment approaches appears more solid at this stage, as much as a function of the number of studies undertaken as their comparative outcomes. Waldron and Kaminer (On the learning curve: the emerging evidence supporting cognitive-behavioural therapies for adolescent substance abuse. **Addiction 2004;99(Suppl, 2) :93-105**) review these interventions and their uses.

Family therapies for adolescent substance abuse have consistently been shown to be effective for a range of outcome measures and compare favourably to standard treatments and most individual-orientated therapies, especially since the advent of treatment approaches targeting research-based target behaviours such as emotional disengagement, family conflict and poor parenting practices. Liddle's "Family based therapies for adolescent alcohol and drug use: research contributions and further research needs" (**Addiction 2004;99(Suppl, 2) :76-92**) reviews the area mentioning a number of specific manualized therapies that are flexible and can be combined with individual treatments such as CBT, with added potency. Significant gains can be found in engagement, retention, reduction of substance use and psychiatric comorbidity, sustained well passed the end of interventions. This paper makes a strong case in favour of specific family-based interventions such as Multi-Systemic Therapy (MST) and the authors own brand, though does not go into sufficient detail to allow readers to incorporate their strategies into clinical practice. Perhaps we need to buy the manuals! Also of interest is the discussion of current research directions involving the identification of particular strategies for dealing with different stages of family change, and the use of the subjects natural antisocial peer groups in treatment to afford change in peer affiliation.

School-based interventions have come under widespread criticism due to the extensive support they have received despite limited evidence of efficacy. "Implementing school-based substance abuse interventions: methodological dilemmas and recommended solutions" (Wagner, Tubman and Gil. **Addiction 2004;99(Suppl, 2) :106-119)** provides a nice discussion of the difficulties researching such programmes and perhaps somewhat hopefully interpret the limited body of evidence in their favour. More useful is the outline of core factors associated with successful programmes, including the use of psychoeducational and skills building components, paying close attention to optimal timing, duration and intensity of interventions, demand consistency through manualization, the involvement and education of teachers and linkage with other related intervention programmes.

Gil and colleagues (**Addiction 2004;99(Suppl, 2) :140-150)** report the results of their study of the impact of acculturation on engagement and outcome of treatment for Hispanic and African-American adolescents. In these ethnic groups, issues of acculturation certainly appear to be related to severity of substance use problems, engagement in treatment and treatment outcome, though the nature of the association appears to differ depending on context, making generalization to other socio-cultural milieu's difficult.

Overall, this supplement provides an interesting and timely overview of adolescent substance use problems and the emerging evidence base for treatment efficacy. Most of the paper authors have considerable investment in the area they review, probably both professionally and fiscally if the frequency of references to manualized interventions is anything to go by. For the researcher, there are useful discussions of the research difficulties and challenges in the area. To clinicians, most of these papers will provide little new though they are generally interesting and informative. The exception, I think, is the paper by Liddle on family therapies targeting key aetiological factors. These interventions appear to have the most empirical support and are likely to be a very useful addition to the clinician's toolbox. Missing is any mention of the emerging area of pharmacotherapy. This may represent a natural reluctance on the part of American clinicians to medicate young people, though given their experiences with the use of stimulants for conditions resembling ADHD, it seems unlikely. Maybe it's just that there is little to be gained from coming up with a manual to describe prescribing medication.

Fraser Todd, Senior Lecturer, NAC

Treatment Research Interest Group (TRIG)

Alcohol, Drugs and Addiction

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The objectives of TRIG are:-

- *To foster interest in scientific research on treatment of people with alcohol and other drugs related problems in New Zealand.*
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- *To support the development of improved treatment services for people with alcohol and other drugs related problems in New Zealand.*

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